State of Hawaii
Department of Human Services

Med-QUEST Division

Medical Assistance Application

Date Received by DHS	**OFFICIAL USE ONLY** Organization Assisting with Application	Case Name Case Number Worker's Name Section/Unit/EW Code ☐ FS/HQ Combo ☐ Medical Only ☐ Upfront AF/GA

1. Please tell us who you are and where you live. This person will receive all mail and phone calls. Also write your name and information in number 3A.

Last Name	First Name	Middle Initial	Best Phone Number to Call	Email Address
Address (Where you live)		Apartment Number	City, State, and Zip Code	
Mailing Address (If it is different from where you live)			What Language Do You Speak Best? *(We will get you a FREE interpreter—see page 7.)*	

2. Please check YES or NO in the boxes below. If you check YES, please complete.

YES	NO		
☐	☐	**A.**	**Is anyone who wants medical assistance pregnant?** *(Unborn children may be counted in the pregnant woman's household size.)* Name_____ Due Date_____ Number of children expected_____
☐	☐	**B.**	**Was the pregnancy confirmed by a home pregnancy test or health care provider?** *(If the answer is NO, we will request verification.)*
☐	☐	**C.**	**Is anyone who wants medical assistance 18-20 years old and claimed as a tax dependent?** *(The tax dependent's parents' or legal guardians' income is counted for the QUEST program.)* Name_____
☐	☐	**D.**	**Is anyone self employed?** *(You may get business expenses deducted.)* Name_____
☐	☐	**E.**	**Is anyone who wants medical assistance in a medical institution or applying for long-term care placement, home and community-based services, DD/MR, or PACE?** *(Program names are listed on page 8. You may be asked to provide more information about assets you owned.)* Name_____ Nursing Home Name_____ Placement Date_____
☐	☐	**F.**	**Is anyone who wants medical assistance 0-18 years old and has an absent or deceased parent?** *(You may be asked to complete more forms.)* Name_____
☐	☐	**G.**	**Is anyone blind, disabled, or 65 years old or older?** *(You may receive income deductions and help with unpaid medical bills.)* Name_____

3. Please tell us about yourself and who lives in your household. List yourself first and use legal names. Write only family members who are responsible for each other, such as spouses, children under 19 years old, and the children's parents. Attach another paper if there are more than 8 persons.

- We need a social security number and citizenship information for each person who wants medical assistance.
- We do not need a social security number and citizenship information if a person does not want medical assistance (non-applicant). However, we may ask for more information if a social security number is not provided.

A. **Last Name**_____ **First Name**_____ **Middle Initial**_____

Date of Birth Month____ / Day____ / Year____

Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

B. **Last Name**_____ **First Name**_____ **Middle Initial**_____

Date of Birth Month____ / Day____ / Year____

Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

C. **Last Name**_____ **First Name**_____ **Middle Initial**_____

Date of Birth Month____ / Day____ / Year____

Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

D. **Last Name**_____ **First Name**_____ **Middle Initial**_____

Date of Birth Month____ / Day____ / Year____

Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

E. **Last Name** _____
First Name _____
Middle Initial _____
Month Day Year
Date of Birth ____/____/____
Age _____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): _____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date: _____
☐ Other (specify): _____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): _____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

F. **Last Name** _____
First Name _____
Middle Initial _____
Month Day Year
Date of Birth ____/____/____
Age _____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): _____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date: _____
☐ Other (specify): _____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): _____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

G. **Last Name** _____
First Name _____
Middle Initial _____
Month Day Year
Date of Birth ____/____/____
Age _____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): _____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date: _____
☐ Other (specify): _____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): _____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

H. **Last Name** _____
First Name _____
Middle Initial _____
Month Day Year
Date of Birth ____/____/____
Age _____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): _____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date: _____
☐ Other (specify): _____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): _____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

4. Please tell us ALL income your household gets each month. If you have no income, complete A and go to number 5.

☐ A. Check here if your household has no income. Tell us how your food, rent, and other living costs are paid:

_____

_____

B. Check YES or NO for **every type** of income listed. If YES, please write information in the boxes and **attach document copies**. Write the person's name and monthly gross amount **(before taxes and deductions—not take home pay)**. Completing this information will help us process your application faster.

YES	NO	Household Income	Person Receiving Income	Monthly Gross Amount
☐	☐	Job: Employer's Name		Total for **Whole Month**
		1.	1.	1. $
		2.	2.	2. $
		3.	3.	3. $
☐	☐	Self-Employment Income		$
☐	☐	Social Security Benefits		$
☐	☐	Supplemental Security Income (SSI)		$
☐	☐	Pension/Retirement Income (write who pays you: _____)		$
☐	☐	Veteran's Benefits		$
☐	☐	Temporary Disability Insurance (TDI) (write who pays you: _____)		$
☐	☐	Worker's Compensation		$
☐	☐	Unemployment Insurance Benefits (UIB)		$
☐	☐	Insurance Settlements (write who pays you: _____)		$
☐	☐	School Grants and Scholarships (write type and dates: _____)		$
☐	☐	Child Support		$
☐	☐	Alimony		$
☐	☐	Child's Income		$
☐	☐	Other Income (please tell us):		$

5. YES ☐ NO ☐ **Does anyone pay for childcare? If YES, please write information in the boxes.** *(You may be allowed these deductions.)*

Person Who Pays	Monthly Cost	Name of Child	Person Providing Care
	$		
	$		
	$		

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

6. Please list ALL household assets as of the first day of this month.

☐ A. Check here if you are only requesting medical assistance for persons who are 0-18 years old or a pregnant woman and go to number 7.

B. Check YES or NO for **every type** of asset listed. If YES, please write information in the boxes and **attach document copies**. Write the owner's name, bank or company name, and value. Completing this information will help us process your application faster.

YES	NO	Assets	Owner's Name	Bank or Company Name	Dollar Value
☐	☐	Checking Accounts (write all)			$
☐	☐	Savings Accounts (write all)			$
☐	☐	Cash			$
☐	☐	Income Tax Refunds			$
☐	☐	Stocks and Bonds			$
☐	☐	Money Market Accounts, CDs, and Time Certificates			$
☐	☐	IRA, Keogh, and Deferred Compensation			$
☐	☐	Home or Mobile Home			$
☐	☐	Other Houses, Land, and Buildings			$
☐	☐	Burial Plans: Total Number _____			$
☐	☐	Burial Plots: Total Number _____			$
☐	☐	Life Insurance (Surrender Cash Value)			$
☐	☐	Family or Individual Trust Funds			$
☐	☐	Business Equity (Self-Employed)			$
☐	☐	Boats and Trailers			$
☐	☐	Jewelry, Diamonds, Gold, Silver, Etc.			$

7. Please check YES or NO in the boxes below. If YES, please write information in the boxes.

YES NO

☐ ☐ **A. Has anyone who needs medical assistance for long-term care, home and community-based services, DD/MR, or PACE sold, traded, or given away money, property, other resources, or assets in the past 5 years?** *(You may not get help if you disposed of assets for less than fair market value.)*

Items Sold, Traded, etc.	Transaction Date	Reason for Sale, Transfer, etc.	Actual Owed	Actual Value	Amount Received
			$	$	$
			$	$	$

☐ ☐ **B. Does anyone who needs nursing home assistance or the person's spouse have an annuity?**

Owner's Name	Annuity Company and Policy Number	Value
		$
		$

8. Please check YES or NO in the boxes below. If YES, please write information in the boxes.

YES NO

☐ ☐ **A. Does anyone listed in Question 3 have private health, dental insurance, vision insurance, long-term care insurance, Medicare, TRICARE, VA benefits, or prescription drug coverage?** *(Other insurance may help pay medical, dental, vision, or drug bills.)*

Person Covered	Insurance Name, Type, and Policy Number	Start Month/Year	Premium Amount
			$
			$

☐ ☐ **B. Has an employer offered health insurance to anyone who is employed?** *(We need to know about employer-sponsored health insurance for the employee only **not** his or her children or spouse.)*

Person Covered	Insurance Name, Type, and Policy Number	Start Month/Year	Employer's Name

☐ ☐ **C. Did anyone lose employer-provided health insurance or extended health care coverage (COBRA) in the past 45 days?**

Person's Name	Last Day Covered

☐ ☐ **D. Has anyone been hospitalized or gone to an emergency room in the past 5 days?** *(We may be able to help pay the bills.)*

Person's Name	Service Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **E. Does anyone who is blind, disabled, or 65 years old or older have unpaid medical bills the past 3 months?** *(We may be able to help pay the bills.)*

Person's Name	Service Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **F. Does anyone have medical problems or need medical treatment due to an accident or incident?** *(The responsible party may help pay medical bills.)*

Person's Name	Accident or Incident Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **G. Does anyone need ongoing medical treatment—doctor visits, prescriptions, etc.?** *(We may be able to help pay the bills.)*

Person's Name	Expected Monthly Cost	Provider (Doctor, Hospital, etc.)

9. Please tell us that you read or had read to you the statement below by signing your name and writing the date.

I certify the information I have provided on this application is true to the best of my knowledge. If I intentionally make false statements on this application, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements. I have read or had read to me the list of rights and responsibilities on page 11 that I may keep for my information.

Applicant's Signature_____ Date_____

10. Certification by Person Assisting the Applicant in Completing this Application

I helped the applicant complete this application or I am applying for an individual who is unable to act on his/her own behalf. I understand that anyone helping an individual to receive benefits dishonestly is subject to criminal penalties. I certify that the answers on this form ☐ were provided by the applicant/recipient or ☐ are what I personally know about him or her.

Representative's Name (Print)_____ Signature_____ Relationship_____ Telephone Number_____ Date_____

[OFFICIAL USE ONLY: MQD EW NAME (Print)_____ SIGNATURE_____ APPLICATION REVIEW DATE_____]

Bilingual and Sign Interpreter Services

☐	Med-QUEST will provide a free bilingual or sign language interpreter. Yes, I need a _____ language interpreter.	English
☐	Med-QUEST 將會供給您一位免費的雙語翻譯員或手勢語的翻譯員。 是，我要一位 (選一個) ☐普通話 / 國語 (M) ☐廣東話 (C) 的翻譯員。	Chinese
☐	Med-QUEST epwe aora emon chon affou ese kamo, mei sinenap non poraus are pomwen poraus. U, U-mochen emon chon affou non kapasen chuuk.	Chuukese
☐	E kōkua a hāʻawi ana ʻo Med-QUEST i kekahi kanaka unuhi ʻōlelo a i ʻole i kekahi kanaka “sign language.” ʻAe, makemake au i kekahi kanaka unuhi ʻōlelo.	Hawaiian
☐	Ti Med-QUEST mangted iti libre nga interprete nga makaammo iti nadumaduma a pagsasao (bilingual) wenno pagsasao babaen iti senyal (sign). Wen, masapul ko ti interprete nga Ilokano.	Ilocano
☐	クエストが、無料で、バイリンガルあるいは手話の通訳をつけてくれます。 はい、私は日本語の通訳が必要です。	Japanese
☐	Med-QUEST 에서는 통역이나 수화 통역사를 무료로 제공 합니다. 네, 저는 한국 통역이 필요 합니다.	Korean
☐	Med-QUEST ຈະຈັດຫາ ນາຍພາສາ ທີ່ເວົ້າໄດ້ສອງພາສາ ຫລື ນາຍພາສາມືກ ໃຫ້ຟຣີ. ແມ່ນແລ້ວ, ຂ້າພະເຈົ້າ ຕ້ອງການ ນາຍພາສາລາວ.	Laotian
☐	Med-QUEST enaj lewōj ejelok wōnen juōn rukok ak rukok kin sign. Aet, iaikuj i juōn rukok kajin majōl.	Marshallese
☐	Med-QUEST pahn kahk sawasikida sewesepehn tohn kawehwei ni sohte pweipwei. Ehi, ih anahne tohn kawehwei ohng ni lokoiahn Pohnpeian.	Pohnpeian
☐	O le a saunia ele Med-QUEST se faamatala upu ile gagana poo le faaaogaina o saini ma lima e aunoa mase totogi. Ioe, oute manaomia se faamatala upu ile gagana Samoa.	Samoan
☐	Med-QUEST le proporcionará un intérprete sin cargo bilingüe o de lenguaje de signos. Sí, necesito un intérprete de español.	Spanish
☐	Ang Med-QUEST ay nagbibigay ng libreng interprete na makakaalam ng iba-ibang wika (bilingual) o lenggwahe sa pamamagitan ng senyas (sign). Oo, kailangan ko ang interprete na Tagalog.	Tagalog
☐	ʻE lava heʻe Med-QUEST ʻo ʻomai e kau fakatonulea ʻo tatau pe kihe lea moe fakaʻilonga lea ʻaki e nima. ʻIo ʻoku ou fiemaʻu e fakatonulea.	Tongan
☐	Med-QUEST sẽ cung cấp một thông dịch viên song ngữ hoặc thông dịch viên ra dấu miễn phí. Vâng, tôi cần một thông dịch viên tiếng Viêt Nam.	Vietnamese

General Questions and Answers

How long does it take for my application to be processed?
Med-QUEST has up to 45 days from the date it receives your application to approve or deny it. However, if the person who needs medical assistance is blind or disabled, they have 90 days to review it. Pregnant women applications are processed within 5 business days if all questions on the application are completed.

What is the difference between QUEST and Fee-for-Service?
Med-QUEST pays health plans for customers enrolled in QUEST, QUEST-ACE, QUEST-Net, and QUEST Expanded Access (QExA). It pays health care providers for customers not enrolled in a health plan.

If I have Medicare, can I still get Medicaid?
Yes. If you qualify for Medicaid, the state may pay your Medicare premiums.

If I have Medicare, will QUEST Expanded Access (QExA) pay for my prescription drugs?
Some drugs not covered by Medicare may be paid by QUEST Expanded Access (QExA).

Do I enroll in a health plan if my application is approved for the QUEST program?
Yes. If you receive a letter from Med-QUEST that your application is approved for QUEST, you must enroll in a health plan within 10 days. You can choose from several health plans by calling our Customer Service Section at 524-3370 (Oahu) or 1-800-316-8005 (Neighbor Islands). You can also fax your request to 692-7224 (Oahu) or 1-800-576-5504 (Neighbor Islands).

Must I live in Hawaii to apply?
Yes. You must be a Hawaii resident. People who need medical assistance must also plan to live in Hawaii indefinitely.

Can only United States citizens get medical assistance?
No. You can be a United States citizen, United States National, lawful permanent resident, qualified alien, or citizen from the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau.

Will enrolling in QUEST or Fee-for-Service affect my immigration status?
No. It will not affect your immigration status. Call the national U.S. Citizenship and Immigration Services center at 1-800-375-5283 for details.

What are the DD/MR and PACE programs?
These programs are Developmental Disabilities/Mental Retardation (DD/MR) and Program of All Inclusive Care for Elderly (PACE). They provide support services so a person can remain at home or live in a community-based setting.

Important Resources

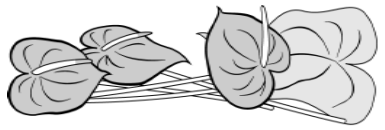
211
Information and referral hotline service sponsored by Aloha United Way. Free call from all islands by dialing 211.

Domestic Violence Legal Hotline
Provides civil legal assistance and advocacy to domestic abuse victims. 531-3771 (Oahu) or www.stoptheviolence.org

Medicare
Information provided by the Centers for Medicare & Medicaid Services.
1-800-633-4227 or www.medicare.gov

Sage PLUS
Provides statewide health insurance information counseling and referrals to people 60 years or older. 586-7299 (Oahu) or 1-888-875-9229 (Neighbor Islands) or www4.hawaii.gov/eoa/programs/sage_plus/

Executive Office on Aging
Dedicated to the well-being of older adults and their caregivers.
586-0100 (Oahu), 974-2400 (Hawaii), 274-3141 (Kauai), 984-2400 (Maui), 1-800-468-4644 (Molokai), or www4.hawaii.gov/eoa/



Common Questions and Answers

Pregnant Women

How long does it take for my application to be processed?
Med-QUEST will process your application within 5 business days if you answer all questions on the application.

What should I do after the baby is born?
Call your Med-QUEST worker and let her or him know the baby's full name and date of birth. If Med-QUEST needs more information, they will contact you. The baby will stay in the mother's health plan for 30 days.

How long will my medical assistance continue?
You will be covered for 60 days after the baby is born. To continue longer, complete Form 1100 to find out if you are eligible as a non-pregnant adult.

If I am not eligible for Med-QUEST's programs, can I apply for my baby?
Yes. If your baby is eligible, benefits begin on the date Med-QUEST receives the application. Also, if you want your birth expenses covered, Med-QUEST must receive your application within 5 calendar days of the baby's delivery. It would be helpful to complete the application before you go to the hospital, take it with you, and ask the hospital staff to fax it to your local Med-QUEST office.

Children

How long does it take for my application to be processed?
Med-QUEST has up to 45 days from the date it gets your application to approve or deny it. However, if the person who needs medical assistance is blind or disabled, they have 90 days to review it.

How soon can my child get health care?
If the application is approved, benefits begin on the date Med-QUEST received the application.

If my child gets sick before the application is approved, what should I do?
Please call a doctor! Private physicians and community health centers can help you. Tell them you have an application pending with Med-QUEST. If you cannot get help because you don't have health insurance, call your local Med-QUEST office and ask for an emergency processing form (1149). Telephone numbers are listed on the last page of the application. You can also download the form at www.coveringkids.com/library/. After the doctor completes the form, bring it to Med-QUEST and they will review your application.

Will enrolling in a health plan or Fee-for-Service affect my immigration status?
No. It will not affect your child's or family's immigration status. Call the national U.S. Citizenship and Immigration Services center at 1-800-375-5283 for details.

Important Resources

211
Information and referral hotline service sponsored by Aloha United Way. Free call from all islands by dialing 211.

Child Abuse and Neglect
Statewide 24-hour hotline. Call if you think a child is abused or neglected. 832-5300 (Oahu).

WIC
Nutrition program for women, infants, and children. 586-8175 (Oahu) or 1-888-820-6425 (Neighbor Islands).

Head Start
Child development programs that serve children from birth to age 5 years old and their families. www.hawaii.gov/dhs/self-sufficiency / childcare/headstart/

MothersCare Information Line
Operated by Healthy Mothers Healthy Babies Coalition of Hawaii. Links pregnant women to health and community resources. 951-6660 (Oahu), 1-888-951-6661 (Neighbor Islands), or www.hmhb-hawaii.org.

Parent Line
Staffed by professionals specializing in child and adolescent growth and development. 526-1222 (Oahu) or 1-800-816-1222 (Neighbor Islands).

Mikah The Myna Bird has friendly advice…

Regular health check-ups are no Myna matter!

EPSDT provides free **E**arly and **P**eriodic **S**creening, **D**iagnosis, and **T**reatment health services for individuals under 21 years old receiving medical assistance through Med-QUEST's programs.

EPSDT offers:

- complete medical and dental examinations
- hearing, vision, and laboratory tests
- immunizations and tuberculosis skin tests
- assistance with scheduling appointments
- help with arranging transportation

☺ Regular health check-ups can keep you healthy ☺

What is EPSDT?
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services is a program that provides regular medical and dental check-ups for individuals under 21 years old.

Why should EPSDT concern me?
It is important that children and youth get regular checkups so their doctors find health problems before they become serious.

Who can use this program?
Individuals from birth through 20 years old receiving medical assistance through Med-QUEST's programs.

How can the person get EPSDT services?
Individuals receiving medical assistance get EPSDT services through participating health care providers.

If you need more information, help scheduling an appointment, language interpreter, or transportation assistance, please call 692-8110 (Oahu) or 1-866-836-0957 (free from the Neighbor Islands).

Good health can make all the difference in your life ... and that's no Myna matter!

RIGHTS AND RESPONSIBILITIES

WHAT I HAVE THE RIGHT TO EXPECT FROM THE DEPARTMENT:

RIGHT TO CONFIDENTIALITY: Federal and State laws do not allow the Department to release any information I have provided without my written permission unless it is directly related to managing the medical assistance programs.

NO DISCRIMINATION: I will not be treated differently because of my race, color, age, sex, national origin, physical or mental disability, or religious or political beliefs. If I am not satisfied with the way I am treated, I should write as soon as possible to the Department of Human Services Personnel, Civil Rights Compliance Unit, P.O. Box 339, Honolulu, HI 96809-0339 or the U.S. Department of Health and Human Services, Office of Civil Rights/Region IX, 90 7th Street, Suite 4-100, San Francisco, CA 94103-6705, Attention: Regional Manager. I may also call the US DHHS at 1-800-368-1019 (toll free) or 1-415-437-8311 (TDD). I can get a Discrimination Complaint Form, Consent/Release Form, and joint Nondiscrimination Notices in multiple languages at http://hawaii.gov/dhs in the Civil Rights Corner.

FAIR AND FRIENDLY TREATMENT: The Department will make an eligibility determination based on facts within 45 days from the date the application is received by the Department or within 90 days for someone who is applying for medical assistance based on a disability. I will be given correct information and treated with dignity and courtesy at all times.

BILINGUAL, SIGN INTERPRETER, OR OTHER ACCOMMODATIONS: All Department oral and written communication to me will be in English. If I do not understand what I hear or read, I will contact the Department right away. I can get free help to access medical assistance with sign or foreign language interpreters, large print, taped materials, or accessible parking, etc.

RIGHT TO ADVANCE NOTICE AND ADMINISTRATIVE APPEAL: The Department must tell me before they take any action that affects my benefits by mailing me a notice. If I am not satisfied with any decision made by the Department that will affect me, I have 90 days from the date on which the notice is mailed to me to request an administrative appeal. I may ask the Legal Aid Society of Hawaii, another community agency, or anyone else to assist me.

PRE-EXISTING CONDITIONS: Federal law limits when health insurance will not pay for a pre-existing condition. If I enroll in a group health insurance plan that does not cover pre-existing conditions, I can get credit for the time I received medical assistance. I must ask for a certificate of medical coverage within 24 months after my medical assistance coverage ends.

EPSDT: All persons under age 21 can have free regular health and dental check-ups under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Participating physicians, dentists, clinics, and health centers provide EPSDT check-ups, diagnosis, and treatments. If requested, I may also receive help with scheduling appointments and transportation for these checkups.

WHAT THE DEPARTMENT HAS THE RIGHT TO EXPECT OF ME:

SOCIAL SECURITY NUMBER: I am required to provide Social Security Numbers (SSNs) for all persons applying for medical assistance. (42 USC 1320b-7; 42 CFR 435.910(a)) The SSNs are used to verify the income and assets of those applying for medical assistance to determine if they are eligible. I do not have to provide my SSN if I am not applying for medical assistance or if I am a non-lawful alien applying for emergency medical assistance. If I do not provide my SSN, it will not affect my children's eligibility. My SSN will not be shared with U.S. Citizenship and Immigration Service.

CITIZENSHIP: Those persons applying for assistance in my household are U.S. citizens; lawful permanent residents; refugees; asylees; persons granted cancellation of removal, or paroled in the U.S.; nationals of American Samoa or Swain's Island; Cuban, Haitian, or conditional entrants; Amerasian immigrants; honorably discharged or active duty military, or their spouse or dependent children; battered spouse or children, or children of a battered spouse under the Violence Against Women Act; citizens of the Federated States of Micronesia, Marshall Islands, or Palau, or permanently residing in Hawaii under color of law; or otherwise authorized by law to receive assistance. I must provide proof of lawful immigration status unless I am not applying for medical assistance, or I am an alien that entered the U.S. on or after August 22, 1996 and am applying for emergency medical services. (42 CFR 435.910(a))

COOPERATION AND GOOD CAUSE: Help is available to me through the Child Support Enforcement Agency (CSEA) if I need to obtain medical support for my children. I do not have to cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get medical support by helping CSEA identify the father(s) of my children. If I do not cooperate because I believe it may not be in the best interest of my household, I must provide information to support this. Without good cause, it will not affect my children's medical assistance, however I will not be eligible for medical assistance unless I am pregnant.

THIRD PARTY LIABILITY: I will give the State of Hawaii any health insurance payments or other money received for medical care for the time anyone in my household receives assistance. If I do not cooperate because I believe it may not be in the best interest of my household, I must provide information to support this. Without good cause, it will not affect my children's medical assistance, however I may not be eligible for medical assistance unless I am pregnant.

ASSETS AND OTHER PROPERTIES: I must give the Department information about any asset or property that is owned by my household unless I am only applying for medical assistance for children or as a pregnant woman. If I get rid of any income, asset or property for less money than the fair market value, it may affect my eligibility for nursing facility level care. An annuity purchased after February 8, 2006 must name the State as a remainder beneficiary.

REPORTING ANY CHANGES: I will report to the Department all changes about my household within 10 days of when I learn of the changes as they may affect my eligibility for medical assistance. Changes to report include, among other things: income; addresses; living arrangement; marriage/divorce; pregnancy; birth; death; insurance coverage. It also includes the injuries from accidents; receipt, transfer or sale of any asset (i.e. home, car, etc.); or receipt of a Social Security Number. I must also report when anyone enters a hospital or public institution, or moves out of the State of Hawaii.

VERIFICATION OF INFORMATION: The Department may contact Federal, State, and local officials to make sure the information that I provide is true. I agree to help the Department, its agents and contractors, and Federal reviewers and/or auditors if my case is reviewed. The Department may call any bank or other financial institution to get information about the accounts that belong to my household.

PENALTY WARNING: All information given by me on all forms is true and complete to the best of my knowledge. If I give wrong information on purpose or have someone give wrong information on purpose to help me get medical assistance coverage, I may have to pay penalties and/or repay any medical assistance I received.

APPLYING FOR MEDICAL ASSISTANCE

Please check to see that you completed all necessary information on the medical assistance application and it is signed and dated. This will help us process it faster. If the application is incomplete, you may be contacted for more information.

You may take your completed medical assistance application to the Med-QUEST eligibility office near where you live or mail it to the address below. You can also fax it to your local office. If you have questions about your application, please call your local eligibility office.

OFFICE ADDRESSES	MAILING ADDRESSES	TELEPHONE AND FACSIMILE NUMBERS
Oahu Section 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817-4582	**Oahu Section** P. O. Box 3490 Honolulu, HI 96811-3490	**Phone 587-3521 or 587-3540** **Fax 587-3543**
Kapolei Unit Kakuhihewa State Office Building 601 Kamokila Boulevard, Room 415 Kapolei, HI 96707-2021	**Kapolei Unit** P. O. Box 29920 Honolulu, HI 96820-2320	**Phone 692-7364** **Fax 692-7379**
East Hawaii Section 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	**East Hawaii Section** 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	**Phone 933-0339** **Fax 933-0344**
West Hawaii Section Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	**West Hawaii Section** Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	**Phone 327-4970** **Fax 327-4975**
Lanai Unit 730 Lanai Avenue Lanai City, HI 96763	**Lanai Unit** P. O. Box 631374 Lanai City, HI 96763-1374	**Phone 565-7102** **Fax 565-6460**
Maui Section Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	**Maui Section** Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	**Phone 243-5780** **Fax 243-5788**
Molokai Unit State Civic Center 65 Makaena Street, Room 110 Kaunakakai, HI 96748	**Molokai Unit** P. O. Box 1619 Kaunakakai, HI 96748-1619	**Phone 553-1758** **Fax 553-3833**
Kauai Unit 4473 Pahee Street, Suite A Lihue, HI 96766-2037	**Kauai Unit** 4473 Pahee Street, Suite A Lihue, HI 96766-2037	**Phone 241-3575** **Fax 241-3583**

Please attach document copies to your application.

It is very important!

Med-QUEST needs **copies** of these documents to process your application faster:

- ☐ CITIZENSHIP OR ALIEN STATUS
  for people who want health insurance.

- ☐ PHOTO IDENTIFICATION
  for people who want health insurance.

- ☐ INCOME
  for items listed in Question 4B.

- ☐ ASSETS
  for items listed in Question 6B.

Thank you.

IMPORTANT—Please Read and Attach Documents to Your Application!

MEDICAL ASSISTANCE APPLICATION

Income and Asset Information

Med-QUEST can process your application faster if you attach copies of your income documents such as a pay stub, Social Security award letter, retirement income statement, or other income proof. Also, if you write assets, you must attach copies.

Request for U. S. Citizenship, Alien Status, and Photo Identification Documents

Please attach one copy of a citizenship or alien status document and one copy of photo identification for each person in your household who wants medical assistance.

If you need help completing the Med-QUEST application, please call 211 (free call from all islands) and ask for an outreach worker near your home. Also, the address and phone number for your local Med-QUEST office are on the last page of the application.

Examples of Documents You Can Attach to Your Application

PHOTO IDENTIFICATION
Please attach **a copy** of ONE ITEM ONLY for each person who wants medical assistance:

- Passport
- State Identification Card
- Driver License or Permit
- School Identification
- Bus Pass
- Certificate of Naturalization or U.S. Citizenship
- Government Issued Card with Same Information as Driver License
- Draft Record
- U.S. Military or Military Dependent Card
- U.S. Coast Guard Merchant Mariner Card
- Certificate of Indian Blood or U.S. American Indian/Alaskan Native Tribal Document
- Permanent Resident Card (I-551)
- Other Official Photo Identification
- Affidavit (Children Under 16 Years Old Only)

U. S. CITIZENSHIP
Please attach **a copy** of ONE ITEM ONLY for each U.S. citizen who wants medical assistance:

- U.S. Passport
- Current Hawaii State Identification Card (front and back)
- Certified U.S. Birth Certificate
- Certificate of Naturalization (N-550 or N-570)
- Certificate of U.S. Citizenship (N-560 or N-561)
- Certificate or Report of Birth Abroad (DS-1350, FS-240, or FS-545)
- Northern Mariana Identification Card (I-873)
- American Indian KIC Card (I-872)
- U.S. Military Record (DD-214)
- U.S. Final Adoption Decree
- U.S. Civil Service Employment Before June 1, 1976
- U.S. Identification Card (I-179 or I-197)
- Verification with Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) Database for Naturalized Citizens

ALIEN STATUS
Please attach a **copy** of ONE ITEM ONLY for each alien who wants medical assistance:

- Permanent Resident Card (I-551)
- Arrival/Departure Record (I-94)
- Recent Arrivals Only: Foreign Passport or I-94 with I-551 Stamp
- Employment Authorization Card (I-688B)
- Refugee Travel Document (I-571)
- U.S. Veteran Discharge Papers (DD-214)
- Active Duty Orders

Lost U.S. Birth Certificates

If someone who needs medical assistance must get a new birth certificate, attach a copy of the birth certificate paper application or electronic confirmation and money order. The Med-QUEST eligibility worker will wait 45 days from the date Med-QUEST received the application to determine eligibility. When the birth certificate arrives in the mail, immediately send **a copy** to Med-QUEST or the person will be denied.

State of Hawaii
Department of Human Services

Med-QUEST Division

Statement of Parent or Guardian for Children Under 16 Years Old

Identity Affidavit for Medicaid Programs (Deficit Reduction Act of 2005)

This form meets the photo identity requirement for children under 16 years old. If the children are not living with a parent, the guardian may complete it. Please print clearly. If there are more than ten children in the household, attach another affidavit form.

I, _____, am the parent or guardian of the children listed below.
(Print Name of Parent or Guardian)

Child's Legal Name (First Name and Last Name)	**Birth Date** (Month, Day, and Year)	**Where Child Was Born** (City and Country)	OFFICIAL USE ONLY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

I certify under penalty of perjury that the information I have provided in this affidavit is true to the best of my knowledge.

Signature of Parent or Guardian

_____
Date